



The Pulse of CMS

“A quarterly regional publication for health care professionals”
Serving Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi and Tennessee.

CMS Seeks Solutions for High-Cost Medicare Seniors

CMS recently announced a demonstration to find ways to improve the health and quality of life of Medicare beneficiaries with high medical expenses while reducing costs for the program and for beneficiaries.

“A relatively small number of people on Medicare, many of whom are very ill, account for most of our spending,” said CMS Administrator Mark B. McClellan, M.D. Ph.D. “We’re going to find the most promising, innovative approaches. And we’re going to provide financial rewards for lower costs *and* better quality.”

The demonstration will study various care management models for high-cost beneficiaries in the traditional Medicare fee-for-service program. These might include intensive care management, increased provider availability, structured chronic care programs, restructured physician practices, and expanded flexibility in care settings.

Fifteen percent of Medicare fee-for-service beneficiaries account for approximately 75 percent of Medicare expenditures each year. For many of these very ill patients, a restructuring of care to

integrate provider services and to deliver those services in locations such as the beneficiary’s home could significantly improve their quality of life while also reducing costs for the beneficiary and the Medicare program.

Information on the demonstration was published in the Federal Register on October 6. The notice invited physician groups, hospitals, and integrated delivery systems to submit proposals for participating in this demonstration. Other types of organizations may apply, as part of a consortium that includes at least one of the above entities that must play a major role in carrying out the demonstration.

Participating organizations may propose a monthly fee to cover their administrative and care management costs, and they may propose a plan to share a portion of the savings from the demonstration. However, organizations will be required to assume financial risk if they do not meet established performance standards.

Information about applying to participate in the demonstration can be found at <http://www.cms.hhs.gov/researchers/demos/cmhcb.asp>

CMS Joins Forces with FEMA in Hurricane Relief Efforts

Nine staff members of the CMS Atlanta Regional Office volunteered to assist the Federal Emergency Management Agency (FEMA) after Hurricane Frances. The 2004 Hurricane Season has produced a record number of violent storms, which have hit the state of Florida within a short period of time. The frequency and severity of the storms taxed the local, state and federal response systems. FEMA requested assistance, under the Stafford Act, from federal agencies including, but not limited to: the Environmental Protection Agency, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, Public Health Commissioned Corps, and AmeriCorps.

Marsha Montague, Vicki Scott-Lewis, Edgar Gallardo, Sondra Rothwell, Julie Taylor, Cheryl Brimage, Judy Weaver, Richard Devon and David Hinson assisted FEMA to perform community outreach in areas impacted by the storm with information and guidance to hurricane victims on requesting federal assistance to repair and rebuild. Residents were fatigued and stressed by repeated evacuations, loss of essential services and, in some cases, loss of jobs and income. Florida has the largest population of Medicare beneficiaries in the nation, many of which suffered extensive loss as a result of the storms. Each resident has their own individual stories of the storms, many of which, involved heroism and sacrifice.

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Pictured: Staff of CMS and FEMA who helped in the recovery efforts of the Florida Hurricanes this summer

CMS Facilitates Enrollment in Drug Card

CMS recently announced new steps to make it even easier for people on Medicare with limited incomes to get large savings on their drug costs. The current initiative facilitates enrollment and provides a streamlined process for the \$600 transitional assistance. Participating national Medicare-approved drug discount card sponsors will agree to follow simple procedures to facilitate the enrollment.

In mid-October, over one million Medicare beneficiaries received an "Important Message from Medicare" and a Medicare-approved discount drug card in the mail. People receiving this important message are likely to qualify for a \$600 credit in both 2004 and 2005. They will be able to use this \$1,200 credit from Medicare to help pay for their prescriptions. There are no enrollment forms to complete and the card begins providing discounts on November 1. To activate the credit, beneficiaries can call 1-800-MEDICARE or the card sponsor's 800-number. Medicare Savings Programs beneficiaries who wish to choose another card can call 1-800-MEDICARE to learn about their other choices.

CMS has developed a "tool kit" of materials for health care professionals and other partners to assist people with Medicare who may be eligible to save money on their prescription drugs. Visit the [CMS website](#) to access the tool kit, which includes downloadable, printable materials.

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E-mail your questions and comments to us at: Atl_Provider_Questions@cms.hhs.gov

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Focus on MMA: New Preventive Benefits

The new preventive care benefits that were authorized by the Medicare Modernization Act of 2003 (MMA) are implemented in the 2005 Physician Fee Schedule final rule, which will become effective January 1. These new benefits are the heart of an initiative to make Medicare a modern prevention-focused program.

Central to the initiative is the "Welcome to Medicare Physical," an initial preventive examination for all Medicare beneficiaries who enroll into the program on or after January 1, 2005. This exam gives physicians the opportunity to make an overall assessment of a patient's health, and provide counseling on nutrition and other steps to stay healthy.

CMS has made two changes to the proposed payment provisions for the physical to ensure that beneficiaries get the maximum value from this service. First, physicians can bill and be paid separately for a screening electrocardiogram, in addition to the payment for the physical. Second, physicians can also bill for a more extensive office visit when performed at the same time as the physical, so long as the services are medically necessary.

Another addition to Medicare is coverage for cardiovascular screening blood tests for the detection of cardiovascular disease or related

abnormalities and coverage for diabetes screening tests for beneficiaries identified as at-risk for this illness.

"When it comes to modern health care Medicare had it backwards, spending 99 percent of its resources treating seniors after they got sick and only 1 percent on preventing illness and promoting wellness," said Health and Human Services Secretary Tommy Thompson. "With the new law, we are reversing this trend and focusing Medicare more on disease prevention and management."

The final rule also dramatically increases payments for vaccinations and other types of injections, reflecting Medicare's rapid action on recommendations from the American Medical Association's Drug Administration Workgroup to assure appropriate payment for all drug administration services. Physicians can also be paid for injections and vaccinations, even when performed on the same day as other Medicare-covered services, something Medicare does not currently allow.

The final rule was published in the November 15, 2004 *Federal Register* and will become effective January 1, 2005. The display copy can be found at on the [CMS website](#).

CMS Seeks Provider Feedback on Medicare Contractor Performance

CMS measures provider satisfaction with the services provided by Medicare Fee-for-Service (FFS) Contractors. The Medicare Contractor Provider Satisfaction Survey (MCPSS), a new initiative sponsored by CMS, is designed to collect data on provider satisfaction with and perceptions about the services provided by Medicare FFS claims processing Fiscal Intermediaries (FIs) and Carriers. The MCPSS will be CMS' initial effort to use provider satisfaction as a standard of measurement to evaluate Medicare Contractors' performance.

CMS has awarded a contract to the survey research firm Westat to administer the MCPSS. A pilot survey of the MCPSS will be sent to a sample of approximately 7,400 Medicare FFS providers beginning in January 2005. Data collection for the pilot will continue through March 2005. The survey will give providers the opportunity to rate their Contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical

review, and provider reimbursement. All information collected will be kept completely confidential, and individual providers will not be identified.

CMS will use the results of the pilot to examine and fine-tune the logistics of the survey administration and further refine the survey instrument. The results will not be used to evaluate Contractor performance. CMS plans to use the MCPSS to support and assist Contractors in using provider feedback to identify and implement "best practices" and quality or process improvement initiatives. If selected, please be sure to complete and submit the survey as soon as possible.

For further information on the MCPSS, contact [Gladys Valentin](#) or [Eva Tetteyio](#) in the CMS Central Office.

Contractor Call Centers Take Time Out to Train

Beginning in June 2004, CMS initiated a 12-month Provider Call Center Training Pilot to test the impact of closing provider call centers for up to 8 hours each month to provide training to customer service representatives (CSRs). Providers who call during the training hours will still be able to use the interactive voice response (IVR) units and will receive a message letting them know when CSRs will again be available.

In order to assess the impact of the pilot, CMS will closely monitor the participating contractors. Each site will receive random calls before and after the training asking CSRs targeted questions which are drawn specifically from that contractor's training plan for that particular month to determine the impact of the training. Future monitoring will include questions from previous months' training to test for CSR retention. CMS will also remotely monitor calls between providers and CSRs to gauge the reaction to the pilot.

Control sites have been selected for each contractor. These sites are approximately the same size, with similar call volume and the same line of business, and in some cases operating within the same corporation as the pilot contractors. Control sites will receive the same monitoring as the participant sites so outcomes can be compared. Baseline telephone performance data have been gathered for each contractor so CMS can determine the impact of the closures on volume, call length, and call completion rates.

The most important measures of success are provider satisfaction and the delivery of consistent and accurate answers. CMS and the participating contractors are very excited about this opportunity. For more information please contact [Lisandra Torres Guzman](#) via e-mail or at (410) 786-3415.

Pilot Call Centers:

Part A

- Palmetto GBA (Palm Harbor, FL)
- Empire (Syracuse, NY)
- Riverbend (Chattanooga, TN)

Part B

- Cahaba (Ridgeland, MI)
- BC/BS Montana (Helena, MT)
- Trailblazer Health Enterprises (Timonium, MD)
- First Coast Service Options (Jacksonville, FL)
- CIGNA (Nashville, TN)

QIO 8th Scope of Work: What's On the Horizon

The three-year contract cycle for the Quality Improvement Organizations' (QIO) eighth Scope of Work (SoW) begins in August 2005. The proposed eighth SoW differs from the current one in that it will aim to promote transformational changes in the ability of providers to achieve higher levels of quality. It also requires the QIOs to prove their ability to do the work specified in each of the subtasks.

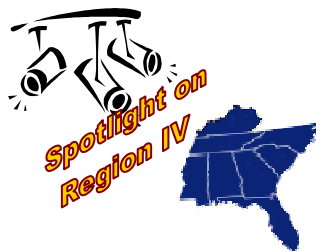
Transformational Change and Breakthrough Priorities: The vision for the 8th SoW is that every person in the health care system receives the right care every time. QIOs are expected to assist providers with developing the capacity to achieve this vision. These organizations will accomplish this by working with providers, practitioners, Medicare Advantage organizations, beneficiaries and other stakeholders in support of quality improvement. Assistance will typically involve promoting improvements in organizational culture, systems adoption and use, and redesign of care processes.

To facilitate this transformational change, CMS has identified a set of "Breakthrough Priorities" for improvement, whose partial purpose is to improve care but, more importantly, to transform the expectations of participants in improvement by making substantial

improvement a fully creditable ambition. Breakthrough priorities have been identified where there is a substantial gap between good practice and actual practice, and where a very substantive improvement in performance is possible. They include: adult immunization, colorectal cancer screening, pressure ulcers, restraints, surgical complications, vascular access for hemodialysis, and workforce turnover in hospitals and nursing homes.

QIO Proof of Ability: Historically, a QIO that holds a contract is considered to be able to perform all of the tasks specified. Because of increasing breadth and complexity of the QIO contract, and the aim to achieve transformation, two new options for executing the work are proposed. The QIO will be required to demonstrate capability for excellent performance on each task. Should they fail to meet the standard, the QIO will be required to subcontract the work to CMS designated organizations.

The Medicare Modernization Act requires the Institute of Medicine to study the QIOs, including their effectiveness. This study is already under way, with the final report due in June 2006. CMS expects guidance from preliminary reports, and will draw from best practices in the private sector and research for evaluating quality improvement interventions.



"The Pulse" will highlight data and facts pertaining to the states in Region IV. This quarter we feature South Carolina in the spotlight. Keep your eye out for more interesting facts from the other states in the region in upcoming issues!

Did you know...

- SC spent \$3,529 per capita on health care in 1998?
- SC is the 33rd largest state in health spending in the nation?
- SC ranks 27th in Medicare spending per enrollee?
- SC ranks 33rd in physician concentration?
- SC ranks 32nd highest in median income?

Additional Assistance after \$600 Credit Is Exhausted

Do your patients need help with prescription drugs? It is useful to know that in addition to the Medicare-Approved drug discount card, seamless assistance may be available through manufacturer assistance programs.

Some drug manufacturers have agreements with Medicare-Approved Drug Discount Card Sponsors to provide continuation of drug discounts or assistance for low-income Medicare beneficiaries after the \$600 transitional assistance credit has been exhausted.

Both www.medicare.gov, through the prescription drug assistance programs "PDAP" tool, and [the CMS website](#) have links to the manufacturer "wrap around" program information, including sponsor names, covered drugs, eligibility criteria, and any co-pays or cost sharing required by the patient.

Go to the [CMS website](#) and select the pharmaceutical company name to view information on the manufacturer program and a list of the Medicare-approved discount drug card sponsors with which they currently have arrangements.

In some cases, manufacturers may have income and eligibility requirements, or have made a business decision to require coordination with the Medicare-approved discount card before their benefits begin. As with any discount program, Medicare patients should compare various Medicare-approved drug discount cards and manufacturer discount/assistance programs to determine which ones best meet their needs.

Reporting Hospital Quality through Collaboration

There is a growing consensus among federal, state, industry, union, employer and consumer stakeholders around the importance of public reporting of hospital quality measures, including those that measure clinical outcomes and patients' perspectives on care. New public reporting initiatives will give consumers information about the health care system that will help them make informed decisions about their care. The CMS Hospital Quality Initiative (HQI) is a significant step toward sustained health care quality improvement and a more informed public.

The CMS HQI, launched in 2003, uses a variety of tools to stimulate and support a significant improvement in the quality of hospital care. The initiative aims to refine and standardize hospital data and performance measures in order to construct a single standard quality measure set for hospitals. The ultimate goal is that all private and public purchasers, oversight and accrediting entities, payers and providers of hospital care would use the same measures in their public reporting activities.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National

Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), American Medical Association (AMA), Consumer-Purchaser Disclosure Project, AFL-CIO, AARP, and others have partnered with CMS in this initiative as the beginning of an ongoing effort to make hospital performance information more accessible to the public. National private sector organizations have also stepped forward to collaborate with CMS to align their quality measurement and improvement efforts. This voluntary reporting collaboration will provide a strong foundation for the identification and use of a standard set of measures across federal, state and private sector quality improvement efforts.

Currently, there are 10 JCAHO/CMS-developed and NQF-endorsed quality measures that are now being reported and that can be viewed on our medicare.gov consumer website. The collaboration is currently working to add additional measures, including surgical infection prevention, later in 2004 or in 2005. Through continued cooperation with our many partners in quality, CMS also hopes to make reporting and collecting data simpler for health care providers, assistance in addressing quality issues and, hopefully, more informed and satisfied consumers.

Calendar of Events

February 8-9 & 20: Annual Provider Association Forum (Inpatient): Hospital, Hospice, SNF/LTC, Rural Health, Atlanta, GA

February 23-25: Annual Provider Association Forum (Outpatient): Physician, Home Health, Pharmacy, Rural Health, Atlanta, GA

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Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region IV provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

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